

Seattle - King County Department of Public Health Notice of Privacy Practices

Effective January 1, 2005

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **PLEASE REVIEW IT CAREFULLY.**

This letter is available in alternate formats that meet the guidelines for the Americans with Disabilities Act (ADA). If you require this Notice in an alternate format, please contact our ADA Liaison at: Phone 206-296-4600 or TTY Relay: 711.

The most recent copy of this document will be posted in all Seattle - King County Department of Public Health care centers and on our web site at www.metrokc.gov/health.

Seattle - King County Department of Public Health is committed to protecting your personal health information. Protected health information (PHI) includes information that we have created or received regarding your health, your health care, and payment for your health care.

THIS NOTICE COVERS THE FOLLOWING ENTITIES PROVIDING YOUR CARE:

All employees, physicians, physician residents, dentists, nurses, administrative staff, social workers, nutritionists, contract staff, medical students, community health providers, affiliated physicians and other health care professionals providing you care through Seattle - King County Department of Public Health care centers and/or programs must abide by this Notice of Privacy Practices. Public Health may share your information with these covered entities to help them provide medical care to you.

Washington State and federal laws require us to provide a higher level of protection for some types of PHI. Washington State law provides a higher level of protection for health care information and specifically limits the disclosure of certain types of PHI, including records regarding mental health, confirmed sexually transmitted disease, HIV/AIDS, and drug and alcohol treatment. Information about this type of care can only be released in accordance with those stricter laws. Minors may consent to their own treatment for family planning services, sexually transmitted disease testing/treatment, outpatient mental health treatment or outpatient alcohol and drug abuse treatment.

PART 1 – YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

Here is a listing of your rights with respect to your protected health information, along with a description of how you may exercise these rights:

- You have a right to request limits on the way we use or disclose your health information. You must make the request in writing to our Privacy Office and tell us what information you want to limit and to whom you want the limits to apply. Public Health is not required to agree to the restriction.
- You have the right to request how we provide confidential communications to you. For example, we may communicate your test results to you by mail or by telephone. You may ask Public Health

to share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address; you may also request that we call you at work instead of at home. You must make this request in writing to our Privacy Office. You do not have to explain the reason for your request. We are required to follow your request, if it is reasonable.

- In most cases, you have the right to look at or get copies of your records. You must make the request in writing to our Privacy Office. We may charge you a reasonable fee based on copying and other costs. In certain situations, we may deny your request and will tell you why we are denying it. In some cases, you may have the right to ask for a review of our denial.
- You have a right to request a correction or an update of your records. You may ask Public Health to amend or add missing information if you think there is a mistake. You must make the request in writing to our Privacy Office and provide a reason for your request. In certain cases we may deny your request, in writing. You may respond by filing a written statement of disagreement with us and ask that the statement be included in your PHI.
- You have a right to get a list of persons or agencies to which your records were sent after April 14, 2003. You must make this request in writing to our Privacy Office. The list will not include the releases of your information made for the purpose of treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your written authorization.
- You have a right to get a paper copy of the most recent version of this notice, if you request it.
- You have the right to withdraw your permission for us to release your information. If you sign an authorization to use or disclose information, you can revoke that authorization at any time. The revocation must be made in writing and given to our Privacy Office. This will not affect information that has already been used or disclosed.

To exercise your rights under the law, call the numbers listed in this document; write our Privacy Office or visit one of the Public Health care centers. Our staff will assist you with your request.

PART 2 – PUBLIC HEALTH’S RESPONSIBILITIES UNDER THE LAW

Public Health is required by law to provide you with our Notice of Privacy Practices. This law is the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under this law, we must protect the privacy of your “protected health information” or PHI. PHI is information that we have created or received regarding your health or payment for your health care. It includes both your medical records and personal information such as your name, social security number, address, and phone number.

We are required to:

- Keep your protected health information private except as indicated below
- Follow the terms of the Notice currently in effect
- Give you this Notice

We reserve the right to change our practices regarding the protected health information we maintain. If we make changes, we will update our Notice and make it available to you. The most recent copy of the Notice will be posted in all Public Health care centers, and on our web site at www.metrokc.gov/health.

PART 3 – HOW WE MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU

Public Health uses and discloses PHI in a number of ways connected to your treatment, payment for your care, and health care operations. Your PHI may be transmitted by FAX for the purpose of treatment, payment or operations. You have the right to ask that we do not transmit your information by FAX. Here are some examples of how we may use or disclose your personal health information without your authorization.

To provide treatment; for example:

- We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses or other healthcare professionals involved in your care. For example, your doctor will need to know if you are allergic to any medicines. The doctor may share this information with pharmacists and others caring for you.
- We may also disclose information to other professionals providing your health care. For example, we may need to tell a specialist about your medical conditions if we refer you to a specialist so you may receive the proper care.

To receive payment for services we provide or to obtain insurance authorization for services we recommend; for example:

- If you have health insurance, we request payment from your health insurance plan for the services we provide. For example, we may need to give your health plan information about your visit, your diagnosis, procedures, and supplies used so that we can be compensated for the treatment provider. However, we will not disclose your health information to a third party payer without your authorization except required by law.
- We may also tell your health plan about your recommended treatment to get their prior approval, if that is required under your insurance plan. For example, if you need surgery, we will call your health plan to make sure the surgery is covered and will be paid for by the health plan.

To carry out healthcare operations; for example:

- We may use or disclose your health information in order to manage our programs and activities. For example, we may use your health information to review the quality of services you receive or to provide training to our staff.
- We may use and disclose medical information to contact you by telephone or by mail as a reminder that you have an appointment for treatment or to inform you of test results.

For Research: We may use and disclose medical information about you for research purposes.

For Joint Activities: Your health information may be used and shared by the Providers in furtherance of their joint activities and with other individuals or organizations that engage in joint treatment, payment or healthcare operational activities with the Providers.

As required by Law: We may use and disclose protected health information when required by federal or state law.

For judicial and administrative proceedings: We may disclose protected health information in response to an order of a court or administrative tribunal; in response to a subpoena, discovery request, or other lawful process.

For law enforcement purposes: We may disclose protected health information to a law enforcement official.

For Abuse Reports and Investigations: Public Health may use and disclose information regarding suspected cases of abuse, neglect, or domestic violence, when the law so requires.

To Medical Examiners/Coroners or Funeral Directors: We may use and disclose protected health information consistent with applicable laws to allow them to carry out their duties.

To Comply with Workers' Compensation Laws: We may disclose protected health information as authorized by laws relating to workers compensation or other programs that provide benefits for work-related injuries or illness without regard to fault.

For organ, eye, or tissue donation purposes: We may disclose protected health care information to organ procurement organizations or entities.

For Specialized Government Functions: We may use and disclose information to agencies administering programs that provide public benefits. For example, Public Health may disclose information for the determination of Supplemental Security Income (SSI) benefits. We also may provide information to government officials for specifically identified government functions such as national security or military activities; or law enforcement custodial situations, such as correctional institutions.

To Avoid Serious threat to health or safety: Public Health may use and disclose protected health information when we believe it necessary to avoid a serious threat to the health or safety of a person or the general public.

For Public Health and Safety Purposes as Allowed or Required by Law: We may disclose protected health information to health care oversight agencies for oversight activities authorized by law.

Disaster Relief: We may use and disclose information about you to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES REQUIRE YOUR WRITTEN AUTHORIZATION:

Uses and disclosures not described in this Notice will be made only as allowed by law or with your written authorization. You may revoke your authorization to use or disclose protected health information at any time; the revocation must be in writing. The revocation will not affect uses or disclosures that have already been made.

PART 4 – HOW YOU MAY ASK FOR HELP OR COMPLAIN

For More Information, please contact:

Privacy Office	Seattle - King County Department of Public Health 999 Third Avenue, Suite 1200 Seattle, WA 98104	Phone: 206-205-5975	TTY Relay: 711
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If you believe your privacy rights have been violated, you may file a complaint with the Privacy Office of the Health Department, at the address above. You may also complain to the Secretary of the U.S. Department of Health and Human Services, at the address below. You will not be retaliated against for filing a complaint.

Office for Civil Rights	U.S. Department of Health and Human Services 200 Independence Avenue, SW, HHH Building, Room 509H Washington D.C., 20201 Phone: 866-627-7748	TTY: 886-788-4989	Online: www.hhs.gov/ocr
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MEMO

TO: Parents/Child Care Providers
FROM: Child Care Health Program
DATE: 7/5/06
RE: Signing for Consent

With the new HIPAA regulations that went into effect in 2003, we are required to ask you to sign the listed forms below in order to provide screening services and share information. Please print legibly and be sure to **sign and date** all forms.

1. Consent for Health Care Screening

- Please fill in all applicable blanks.

2. Authorization for Care Coordination for Use and Disclosure of Protected Health Information

Please fill in front page including:

- Signing and dating the section “**Release of information is authorized for**” and
- In the section “**Records will be released to**” e.g., write the name of the agency or person (i.e., childcare center, family physician, etc.), their phone number & the contact person.

3. Acknowledgement of Receipt of Notice of Privacy Practices (English in blue, Spanish in green)

- Please write the name of child after “Client Name”.
- Parent/guardian must sign and date the bottom of this form.

Notice of Privacy Practices

This blue brochure is to be read and retained by the child’s family.



HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Dorothy F. Teeter, MHA, *Interim Director and Health Officer*

CONSENT FOR HEALTH CARE SCREENING

Child Care Health Program

I give permission for my child: _____
Name of Child

Birthdate Age

To receive health promotion screening services provided at the childcare facility listed below by the staff of the Child Care Health Program at Public Health—Seattle & King County, including, but not limited to vision, hearing, dental, development, speech and behavior. I will be informed of the screening results.

Name of Child Care Program Phone #

Address City ZIP

This consent may be revoked by me at any time.

Date

Parent or Other Legally Responsible Person's SIGNATURE

Witness

Relationship of Legally Responsible Person to Above Child

Interpreter

Street Address

Interpreter's Agency or Relationship to Parent or Other Legally Responsible Person

City State ZIP

Home Phone Work Phone

6/24/03 Child Care Health Program

Child Care Health Program

1916 Boren Avenue, Suite 200 • Seattle, WA 98101

T (206) 296-2770 F (206) 296-2750 • www.metrokc.gov/health



City of Seattle
Gregory J. Nickels, Mayor



King County
Ron Sims, Executive

AUTHORIZATION FOR CARE COORDINATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The undersigned authorizes Public Health or its staff to exchange information (written or verbal) to the persons or organizations identified below for the purpose of ongoing care coordination. A Care Coordination Authorization form is needed for each client.

I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

I give my specific authorization for these records to be released, unless I check any of the boxes below. When checked, this consent **excludes** release of the following types of information:

- | | |
|---|--|
| <input type="checkbox"/> Drug or alcohol abuse diagnosis or treatment | <input type="checkbox"/> Psychiatric care/mental illness |
| <input type="checkbox"/> Confirmed STD test results and/or treatment | <input type="checkbox"/> HIV (AIDS) testing/treatment |

Release of Information is authorized for:

_____ Client Name	_____ Alias	_____ Date of Birth
_____ Signature of Client or Guardian	_____ Relationship	_____ Witness or Interpreter
		_____ Date

Records will be released to:

Agency Name	Telephone	Contact Person	Date

This authorization may be renewed three times.

Unless revoked or as otherwise provided herein, this authorization expires _____ (**insert either applicable date or event**). If this authorization requests that health information be used by or disclosed to the client's employer or a financial institution, this authorization will expire 90 days from the date signed.


Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Client rights on the second page.

This is a permanent part of the health record

<p>CARE COORDINATION AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION</p>  <p>Public Health Seattle & King County <small>HEALTHY PEOPLE. HEALTHY COMMUNITIES.</small></p>	<p>Patient Name: _____</p> <p>HR #: _____</p> <p>D.O.B.: _____</p>
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Your rights under federal and state law:

You may revoke this authorization at any time. It will be in writing. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable.

Public Health may not refuse treatment to you or the person under your guardianship if you do not sign this form.

When Public Health asks you to fill out this authorization, you are entitled to a copy.

You may ask to have this authorization expire sooner.

When Public Health discloses your health information, your protected health information can be subject to re-disclosure by the recipient and is no longer protected by Public Health.

This is a permanent part of the health record